The Path to Transformation – Draft 1115 Medicaid Waiver Application Comments

Submitted by:
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Upon review of the draft 1115 waiver, *Path to Transformation,* members of the Illinois Alcoholism and Drug Dependence Association (IADDA) found the document to be lacking in attention to the critical issues of prevention and treatment of substance use disorders (SUD). Assuming this dearth of information is not a simple oversight, it is disturbing to think an effort of this magnitude ignores addiction as a significant public health issue. (Mention of substance use or substance abuse appears only eight times in a 78 page document). The impact of addiction weighs heavily on other systems, and criminal justice, hospital emergency departments, education, and child welfare are just a few examples. "Substance abuse is clearly among the most costly health problems in the United States" (*National Institutes of Health [NIH], 2000)* Does Illinois want to ignore a public health issue that costs taxpayers millions of dollars through its rippling effects on other systems?

Following are points that were submitted in IADDA's previous comments, but were seemingly disregarded when the current draft document was prepared.

- **Addiction and mental illness are both chronic diseases of the brain.**
- **Both populations experience high rates of trauma and abuse, and both are stigmatized.**
- **Both populations have criminal justice and public safety implications and consequences; SUD has great potential for cost savings in other systems, particularly criminal justice, if appropriately treated.**
- **Individual patients have either a primary diagnosis of addiction or mental illness and many may have a co-occurring disorder, but people with SUD seldom have a severe and persistent mental illness.**
- **The type, size and scope of services used to prevent and treat each illness vary significantly.**

Further, the draft waiver implies that SUDs are merely another type of mental illness, or that they may be apart from behavioral health. Examples of that misconception can be found throughout the document, i.e., page 14, *"…implement a population screening measure that allows better identification of patients with mild to moderate depression and related behavioral health disorders (anxiety, grief, substance use)."*

However, for more than 30 years, addiction (specifically alcoholism) has been recognized by the American Society for Addiction Medicine (ASAM) as a "*complex primary physiological disease, and neither a primary behavior disorder nor a symptomatic manifestation of any other disease process.*" In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 57.2% of persons with SUDs do not have a co-occurring Mental Health diagnosis. The waiver ignores this population in developing and maintaining access to community based SUD services.

The perception that SUDs are apart from behavioral health is also apparent on page 17*, "…drive integration of services across the full continuum (including behavioral health,* substance *abuse and long-term care)."* If this approach is adopted, then each time behavioral health is referenced, SUDs should be referenced as well. IADDA is not necessarily advocating this construct, but clarification and consistency is needed throughout the document.

Housing is identified within **Path #1,** but the exclusion of IADDA's previously provided comments pertaining to housing services for persons with SUDs is another example of a limited knowledge of addiction treatment and its role within public health. Following are IADDA's previous comments on this topic:

> Persons with SUD's require housing as a foundation for long term recovery. The most complex level of SUD care that can provide housing is the American Society of Addiction Medicine (ASAM) Level 3.5 residential care. Residential inpatient treatment encompasses intensive individual and group clinical services while the patient resides in a licensed health care facility. A 2004 NIH study conducted in Illinois demonstrated that ASAM Level 3.5 residential treatment, while initially costing more than intensive outpatient or outpatient treatment, had the greatest return on investment and produced the most long-

term savings *(Dennis, M. and Scott, L,. NIH-NIDA Grant No. R37 DA011323 [2004]).* However, current Medicaid policy does not allow billing for the domiciliary portion of a patient's stay. The billings are divided between Medicaid and General Revenue Funding (GRF), and a domiciliary portion of charged to GRF. A significant disparity occurs when comparing this level of care with a hospital stay. Patients do not experience separate billing for their "room and board" while in an inpatient hospital facility. Hospitals have successfully negotiated inclusion of their room and board costs within their rates, but to date, licensed providers of SUD treatment have not been allowed to do so. This flies in the face of the new parity mandate, and reflects a greater burden on GRF.

Also within the rubric of housing are recovery homes and residential extended care facilities. Neither of which is currently covered within Illinois' Medicaid State Plan. Both are forms of supportive housing that provide structure, access to community based resources, and are geared to support recovery from SUD's. The residential extended care service provides a number of outpatient treatment hours in addition to housing. This clinical component further stabilizes the path to recovery as patients seek employment or establish a support network. This does not differ greatly from some of the services described within the Residential Habilitation definition, page 58. While a less restrictive environment, recovery homes have also proven their worth, and have been well researched, (*Polcin, D.L., Dorcha, R.A., Bond J. and Galloway, G [2010]).* The citation of the Culhane paper on page 41 of the draft waiver adds further credence to the worth of stable housing in aiding recovery.

The draft waiver fails to address one of the most troublesome issues facing persons who require residential treatment Level III.5. IADDA and the provider community were extremely disappointed with the lack of attention to the **Institutions for Mental Disease (IMD) exclusion**. The expansion of access has been touted as one of the primary facets of the *Path to Transformation.* As addressed in IADDA's previous comments, the IMD exclusion looms as a significant access limitation for persons requiring Level III.5 residential care for SUD, and yet, there was no mention of this critical issue. Many SUD inpatient facilities cannot meet the IMD criteria of having fewer than 16 beds, or would have to significantly reduce the number of beds to meet the criteria.

Persons will be forced to seek treatment in a much higher cost hospital setting, continue to be incarcerated, or be housed in a State mental health facility awaiting residential bed availability in a SUD treatment center. There is a glaring inequity as parity issues are raised again. **For no other condition i.e., SUDs, are Medicaid services excluded in certain medical institutions.**

IADDA recently learned that the specific positions listed within the **Path #4, Workforce** section, are meant to be examples, and not an all-inclusive list. Consequently, IADDA would like to reiterate the need to address the serious shortage in the SUD workforce. The opportunity for loan repayment and the ability to participate in ongoing training would provide incentive to persons contemplating entry into the SUD workforce or those SUD professionals already practicing. In addition to those acting in a clinical capacity, there is a body of research and a high level of interest within the Centers for Medicare and Medicaid Services (CMS) to augment some workforce activities through use of peer mentors/recovery coaches. (*CMS Guidance on Peer Support Services, August 15, 2007, SMDL#07-011)* Further, the Illinois Department of Healthcare and Family Services' September 2013, *Report on Detoxification Services Planning process and Resulting Recommendations* endorses a recovery coach model.

Prevention is a component of the Affordable Care Act, and appears in the *Path to Transition* draft waiver as well. One of the many functions of prevention is raising community awareness and spreading the message of healthy living. Within that falls prevention of SUDs. The once strong and viable SUD prevention system in Illinois has been decimated. Rebuilding it through its inclusion as a Designated State Health Program, and addition of Community Intervention and Early Intervention as Medicaid billable services through the waiver will strengthen community-based health education as both are integral to the continuum of care.

Cautionary Note: There is an important issue that was not addressed in our previous comments: In order for Illinois to maintain its current level of funding from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, (approximately $78 million) the State must continue its level of GRF to satisfy a stringent

Maintenance of Effort (MOE). Consequently, GRF funds should not be diminished and replaced by Medicaid funding.

Thank you for the opportunity to comment once again. However, IADDA is very disappointed that our previous comments seem to have been ignored. We have been and will continue to be an active partner in this process to highlight the critical role that SUD addiction prevention, treatment, and recovery play in the overall health of Illinois' citizens. In the realm of general comments, IADDA feels that the current waiver document presents a number of opportunities to include and define substance use disorder treatment and prevention services. We are hopeful that the final document addresses what is missing when speaking of addiction treatment and related prevention. Should you have questions concerning this or any other of the comments, IADDA is ready to assist in combing through the document and providing those appropriate references and explanations. This includes the narrative as well as lists and appendixes. Thank you for your consideration of our comments.